Packaging of Radiologic Guidance Codes and Radiologic Supervision and Interpretation Codes

Issue

Should CMS package the costs of radiologic guidance and radiologic supervision and interpretation services whose descriptors require that they only be performed in conjunction with a surgical procedure?

Background

There are a number of reasons why CMS packages the costs of certain procedures. One reason is clinical in nature. Certain procedures, such as "add on" procedures and radiology guidance procedures, should never appear on a claim without a primary procedure. For example, a facility should not submit a claim for ultrasound guidance for a biopsy unless the claim also includes the biopsy procedure, as the guidance should only be necessary when a biopsy is performed. Claims submitted that contain only a packaged guidance procedure (or a supervision and interpretation procedure whose descriptor requires it be performed in association with a surgical procedure) would be returned to the provider for correction and resubmission.

Another reason CMS packages the costs of procedures is to use as many single claims as possible to determine relative weights. Under the OPPS, relative weights are determined using single procedure claims only. When claims containing a number of procedures are submitted, we determine whether those procedures are packaged or not. If a claim contains a code for only one primary procedure with all other codes being packaged, we can treat that claim as a single bill and use it to set relative weights. This allows us to increase the number of single claims we use to set relative weights. (If the claim contains more than one primary procedure, we do not use it to set relative weights, but we do include the costs on that claim when we compute payment rates.)

Finally, we must use packaging because billing conventions allow hospitals to report costs for certain services using revenue center only (no HCPCS). For those services, it is impossible to accurately assign those costs to each primary procedure on the claim, as there is no way to determine which costs billed under the revenue center belong to which primary procedure listed on the claim. For example, three items appear on a bill: two surgeries and one line item identified by revenue center only (no HCPCS) that contains costs for recovery room. It is impossible to determine which part of the recovery room costs should be allocated to which surgery. Packaging these costs by revenue center thus allows the costs for these procedures to be captured in the data and used for determining payment rates.

Discussion

CMS believes that "packaging" helps to accurately reflect the true costs of providing services under OPPS.

For 2002 CMS has packaged the costs of radiologic supervision and interpretation codes used in conjunction with the endoscopic catheterization of the biliary and pancreatic ductal systems CPT codes 74328, 74329, and 74330). The result of this is that we feel we are more accurately capturing the true cost of providing ERCP services that require radiologic guidance and supervision. (see table below)

		APC	Relative Weight	Payment Rate
Calendar Year 2001				
	ERCP	151	10.53	$529.04
	Level II Misc Radiology Procedures	264	3.83	$192.43
2001 Payment				**$721.47**
Calendar Year 2002 Payment	ERCP	151	15.29	**$778.32**

Packaging the costs of guidance (or S & I) will ensure that appropriate multiple procedure claims (e. g. claims containing the surgical procedure and the radiological procedure) are used to determine the relative costliness of providing ERCP services.

For those procedures where no guidance, ultrasound guidance, CT guidance, or MRI guidance, are used, a single payment rate for the surgical procedure will reflect the relative proportions of the use of each type of guidance. The payment will reflect the mix of guidance services provided for that procedure and unless a facility specializes in a particular type of guidance, the payment amount should, on average, be appropriate.

Absent packaging of these services, CMS is concerned that inappropriate payments will be made for both the surgical and radiologic costs of the procedure.

Attached is a list of the codes for which CMS wants the panel to make recommendations concerning packaging.